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# Different but Same: A Call for a Joint Pro-Active Regulation of Cross-Border Egg and Surrogacy Markets

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## Introduction

Globalization provides new potential for the scope and reach of reproductive service markets through the expansion of cross-border surrogacy and egg markets. As the technology advances in both contexts, gestational surrogacy and egg markets, new cases are emerging in the media and the courts, exposing questionable business practices, and raising obvious needs for regulation. Surprisingly, while there are many calls for global regulation of cross-border surrogacy markets, the parallel call to regulate egg markets is not as prevalent, reflecting a difference in how egg retrieval and surrogacy are viewed. This article probes the question of why the surrogacy market garners so much more attention than the egg market. It specifically considers whether there is a reason to differentiate the egg and surrogacy markets, or whether they are similar in terms of motives for regulation.

The article offers two levels of analysis. First, whether to legitimize either one of the markets. Second, if allowed, or at least not forbidden, how to regulate market failures. Within each one of these analyses, the article asks whether the answer should be different when applied to the egg and surrogacy markets. Part I shows that many of the rationales, either to allow or to forbid each market, apply to both the egg and surrogacy contexts similarly. However, the paper claims that there is no justification to completely prohibit either market. Given that some sort of commodification will have to be acknowledged, Part II reviews the conduct of both cross-border markets and the main failures that raise the need for regulation in each market. The paper emphasizes that for both egg and surrogacy markets similar market failures are relevant, raising the need for regulation. In light of the international calling for regulation of cross-border surrogacy markets, Part III explains why initiatives focus more on surrogacy rather than on the egg market. It asks why only the surrogacy market has taken the initiative to regulate the market, although in both egg and surrogacy markets the protection of "assisting women"[1] should be one of the motives for regulation. Since motives for regulation are similar in both markets, it concludes that the protection of assisting women is not the main motive fueling such regulation. Part IV considers two possible regulative approaches: a minimalistic and a pro-active approach. The article applies both to the two markets. The paper supports a pro-active legal approach not only because it gives the same protections as the minimalistic approach, which provides for safety and basic human rights safeguards, but also because it addresses the social structure and class differentiation when it aims to ameliorate women's expectation for recognition.

Nevertheless, either of these approaches requires the adoption of a single regulative framework for both egg and surrogacy markets.

## I. Are There Different Reasons to Allow or Forbid Egg and Surrogacy Markets?

There is a debate whether to allow markets in egg or surrogacy services or try to abolish them (if commodities in these markets should not be for sale). The sale of body parts and reproductive capacities are the subject of lively discourse. Critics claim that market norms fail to properly value some goods whose distributive criterion belongs to a unique sphere of valuation, or that we should take out of the market entities for which money is not a good distributive criterion.[2] This line of argument, which I call "the intrinsic-value based argument", criticizes any form of commercialized reproductive services, and seeks to abolish them entirely by, for example, criminalizing the commercial provision of these practices.[3] An intrinsic value-based argument implies that commercializing reproductive services may contradict the public good, or pose other moral hazards requiring a regulation to abolish the practice. Both egg and surrogacy markets may jeopardize such moral standards by posing a threat to dignity. Exploring the general discourse about commodification of reproductive services is beyond the scope of this article. Instead, this section focuses on three arguments often used in order to require a regulation that abolishes either market: the intent to create future life; physical implications on the female body; and selling an inalienable commodity. The main question is whether the differences between egg and surrogacy services imply that, based on these arguments, one could be commodified while the other should not.

### a. Commodification of Future/Potential Life

Both egg retrieval and surrogacy deal with the commodification of what is, at the time of transacting, "future life." The payment in exchange of undergoing a procedure or providing a service that results in a life of a person is often seen as wrong and degrading.[4] Commentators often mention that the payment is given in exchange for the discomfort and exposure to medical risk for egg retrieval or pregnancy, and not for the life of a future human being.[5] This is probably due to the intent to avoid the concept of market in future life. Analogously, fewer potential medical risks and discomfort in sperm markets, which also transact "future life" but hardly bear risks, may explain why those are acceptable and do not raise the same sort of objection.[6]

Just as the avoidance to conceptualize the commodification of future life applies to both services, so do the critiques. It is doubtful that payment is given in exchange for discomfort or exposure to risk.[7] If payment in the egg market was given to compensate for discomfort or risk—given that all egg providers and all surrogates go through the same procedure and are exposed to the same potential discomfort and risks—standard procedures should have had one tariff. Albeit, a different tariff for surrogacy services and egg recruitment. Procedures carried out in places that expose women to higher risks, for example in countries or clinics with less advanced facilities or procedure that end in infections or complications, should have provided assisting women with an additional fee because of the extent of the physical risk that they are exposed to.

Conceptualizing the payment as payment for discomfort may hide the inconvenient perception of paying for future life, but the market does not avoid the pitfalls the conceptualization aims to bypass. Effectively, some egg sellers are paid much more than others, not because of additional discomfort, but rather because their eggs embody greater potential for obtaining children with certain traits: height, eye color, athletic abilities, academic degree, etc..[8] The more socially desirable the traits, the higher the demand and the price paid "for the procedure," or maybe for the value of future life that the eggs bear.

In surrogacy, "future life" is embodied not necessarily in the price, but rather in the payment conditions that attach the service to the bottom line of a "take home baby."[9] In the current payment practice, at least part of this money is paid only with the successful delivery of a "take home baby," regardless of discomfort.[10] Surrogates are paid in several payments after conception, but if they cannot conceive, they often will not be paid at all, or get paid only very small amounts.[11] When pregnancy is achieved, surrogacy contracts often state that the surrogate will not receive any compensation if she miscarries before a certain point. If she miscarries after that established point, or if the baby is stillborn, she will receive only a small amount of compensation.[12] The success rate for living birth for three cycles of In Vitro Fertilization (IVF) treatment is 45 percent, and slightly higher for pregnancy and live births per successive cycle.[13] It means that even if a surrogate woman goes through three cycles of IVF, there is approximately a 55 percent chance she will not end up birthing a living baby. Despite substantial physical and emotional discomfort, most cycles do not successfully produce a child, so the surrogate will not be paid the full amount. The surrogacy market does not only commodify the risks and discomfort of the medical procedure itself. Rather, they commodify the creation of future life.

If future life is commodified, the difference between egg and surrogacy transactions may play a role. The success rate of egg retrieval are more likely to advance the commodification of future life. Success rates for retrieving eggs are 71.1 percent for the majority cycles of egg retrieval,[14] in comparison to only 45 percent for a successful live birth per three cycles of IVF.[15] However, each technology is placed on a different stage to achieve a child: egg donation transactions conclude with a transfer of eggs, which is not even an embryo and is therefore more remote from a "future life." Surrogacy transactions involve an embryo, a fetus, and eventually creates a "take home baby."[16] However, this should not necessarily make a difference in regulation. Often, in the discussion about egg markets, it seems that the desired result is the eggs themselves. Yet, though eggs do not immediately become a living human being on their own, no buyer's purpose is to *own* a functional organ as she would own a kidney for its bodily function. The purpose of the transaction is to create independent life.[17] Many patients will keep buying eggs until they result in an embryo, then a child. The different stage in the process of creating future life seems therefore a technical, rather than a substantial difference.

If it is illegitimate to commodify the creation of future life in the market, then markets for both technologies qualify for similar banning regulation. Regulators should acknowledge, though, that abolishing these services on the basis of the creation of future life should apply to other markets that trade "life-giving" factors, such as sperm. Moreover, maybe even organ

markets should be abolished on the same basis, since organs such as kidneys grant life to persons with poor prospects to live.[18]

### b. Harmful Medical Procedures

In the markets of both egg and surrogacy procedures, women give away certain control over their body and submit it to invasive medical procedures. Those procedures expose them to physical risks and require professional medical supervision and control.[19] Major differences in the type of hardship and gravity of the physical risks between egg retrieval and surrogacy services might imply that one market should be abolished, while the other considered acceptable.

Egg providers must agree to take hormones for about ten days and go through a single, invasive medical procedure.[20] First, an egg provider must undergo hormone stimulation to increase the number of eggs that can be harvested.[21] Hormone treatment may cause side effects, such as heat waves, nausea, and headaches.[22] Some women suffer hyper stimulation syndrome, a potentially life-threatening reaction.[23] The process is also believed to expose women to a higher risk of contracting cancer later in life.[24] Second, the egg provider undergoes trans-vaginal ultrasound aspiration, a surgical procedure in which the doctor removes the mature eggs from the woman's body while she is under conscious sedation.[25] Since "harvesting" eggs must occur at a certain time, the egg provider must also agree to be called to the clinic for an ultrasound imaging that shows whether the provider's eggs have sufficiently developed. The entire procedure from hormone stimulation to retrieval takes a couple of weeks.[26]

Surrogacy involves a longer-term contract, requiring a woman to undergo nine months of monitored pregnancy to safeguard the wellbeing of the fetus and the surrogate.[27] Monitoring includes repeated medical examinations, ending in labor that has its own set of difficulties and risks. Pregnancy-related medical problems include, for example, anemia, ectopic pregnancy, gestational diabetes, high blood pressure, severe and persistent nausea and vomiting during pregnancy, vaginal bleeding, infections, preterm labor, miscarriage, depression, and complications that can occur during childbirth.[28] In addition to continuous medical supervision, for several months the process subjects women to major behavioral constraints. During the pregnancy, surrogates should neither smoke or drink alcohol, nor in any way endanger the pregnancy.[29]

The nature and duration of egg retrieval risks and restrictions are very different from those of providing surrogacy services. Regulators may look at the risks as acceptable for one technology and not for the other, requiring regulation that abolishes one and permits the other. However, the difference between egg retrieval and surrogacy procedures seems less relevant to the argument for abolishing the market than the difference between commercialized and non-commercialized practices, which entail the same risks. Hence, if risks alone justified a complete ban on a given procedure, they would justify a complete ban on both commercialized and non-commercialized practices. Since it is often acceptable for women to undergo non-commercialized surrogacy and egg donation, the harms associated with these medical procedures are insufficient to justify a complete ban on either egg or

surrogacy markets. However, any permissive regulation should address the particular risks and characteristics, as discussed below in section II (a).

### c. The Inalienability Involved in Reproductive Commodities

Another aspect of the use of the female body, which may justify abolishing regulation for either one of the markets, connects the use of human body parts with dignity. Scholars claim that putting a price on a woman's body will then allow for the price of a human being. Since "everything has either a price or a dignity",[30] something with a market value cannot have dignity. Specifically, some scholars argue that the female body, sexuality, and reproduction are more integral to her identity than other productive capacities, and therefore inalienable to a woman's personhood.[31] The major concern is the same for both technologies: that women will be perceived as "an abstract, fungible unit with no individuating characteristics,"[32] possessing several alienable "objects." That is, women will be seen merely as an incubator or an egg machine rather than a person, and thus the commodification would harm their worth as unique and valuable persons.[33] This subsection focuses on whether the inalienability involved in either surrogacy or egg markets should lead to creating a regulation that abolishes one market but allows the other.

Two relevant counter-arguments may lead to different conclusions regarding the right approach towards potentially inalienable commodities. First, not all transactions that use the body have the same inherent value. For example, one technology may have more inherent value—and thus should be abolished—while the other could somehow be commodified. One may argue that there is a difference between the sale of egg and surrogacy services in the item being commodified, and, therefore, the inherent value that each technology bears is different. In egg transactions, the commodification aspect is very similar to selling a human organ or tissue in surplus because a human organ is detached from the woman's body until it becomes the property of the person who bought it. The surrogate, on the other hand, does not lose any part of her body. She carries the child, which is made of genetic material that does not belong to her, and gives the child away at birth. She does not sell, but rather commodifies her uterus, which she "rents" or uses to provide "carrying services." Thus, egg sales and surrogacy services are slightly different. In egg donation, the commodification focuses on the sale of human body parts or tissue, whereas in surrogacy, it addresses a rental of a human organ, the uterus.

If only one of the two practices alienates aspects of a woman's personhood in such a way that complete abolition is justified, which practice is it—egg selling or womb rental? Eggs are not renewable like blood or hair—organs that are acceptably exchanged for money. Rather, a woman is born with approximately one million eggs, and during her reproductive time life only 300 to 400 will be ovulated.[34] In contrast to kidney harvesting, the size of a woman's egg pool is not significantly impacted by donation, which makes it easier to trade in eggs as compared to other essential organs. A surrogate "rents" her body for a longer period during which she is impacted physically and emotionally. [35] A surrogate is requested to provide "motherly" care during the pregnancy (in this aspect their work is more similar to care work). She can grow attached to the fetus, and this may add to her emotional burden and to the inalienability of the service she provides.[36] She should control her emotions

immediately after the transaction is completed, and refrain from forming a relationship with the child that she birthed.[37] Egg recruitment requires a lower level of intimacy than surrogacy, since it consists in a technical procedure conducted under anesthesia in which no emotional burden is imposed on the woman in question. To that degree, egg recruitment is less alienating to a woman's personhood than surrogacy. The different physical and emotional burdens may be a reason to prohibit surrogacy markets all together, unlike the egg market, or it may require at least a different regulative model for each market.

This conclusion, although relevant, might be reverse when analyzing the genetic connection to the future child. If the inherent value of the procedure relies on the genetic characteristics that are inalienable to the provider's personhood, then regulators may need to prohibit egg markets. In egg transactions, 50 percent of the genetic material reflected in the genetics of the resulting child belongs to the egg provider. This could imply that the future child bears the genetic characteristics inalienable to the egg provider's personhood, which are being sold. If genetic connection bears a greater inherent value than gestational connection, it may be a reason to prohibit the egg market but to allow surrogacy markets. However, studies show that gestational connection is highly valuable as well.[38] Maternal stress[39] and "adversity"[10] might induce long-lasting effects on offspring outcomes morphology, physiology and behaviors in later life. These traits are also inalienable to the women, making the epigenetic connection a reason to prohibit surrogacy markets. Society may decide that one type of connection is stronger than the other. Thus, one market injures inalienable aspects of a woman—and should be abolished, while the other is alienable—and acceptable. However, there are plausible arguments for the conclusion that both technologies implicate comparably inalienable aspects of personhood. These arguments suggest that a similar regulatory approach is justified in both cases.

The second counter-argument claims that inalienability is insufficient to justify abolition of one practice but not the other. First, it is debatable whether one practice is alienable while the other is not. Social conventions regarding the inherent value in eggs or the uterus are incoherent and open to many definitions, according to personal and cultural symbols.[41] But even if both technologies commodify something integral to a person's identity, there may not be anything debasing about it or harmful to the extent that it requires an abolishing regulation.[42] While some women may find commodifying certain bodily procedures degrading to their bodies, humanity, family, or reproduction, other women might find it empowering and valuable. Prohibitive regulations based solely on this argument may express the view of conservative legal moralism about technologies and an invasion of privacy.[43]

In light of these disagreements, international consensus on abolishing regulation of either one of the markets is hard to find.[44] Eventually, determining what values a state should support and deciding whether to allow or prohibit each market is a political endeavor. Different moral approaches are expressed in a legislative disharmony. Many affluent countries restrict the commercial provision of these technologies, so their citizens embrace less-restrictive regimes, usually in lower-income countries, to purchase egg and womb services.[45] This reality adds a practical enforcement challenge to any regulation that will try to abolish either one of the markets, especially when the markets are legal where transactions are conducted. In recent years, more lower-middle income countries are closing

their gates to foreigners who seek reproductive services.[46] Yet, the market adapts quickly to banning legislation and the hub destinations for cross-border surrogacy transactions keep moving from places that closed their gates to new destinations where such a practice is not banned yet. For example, India's ban of surrogacy provision to foreigners[47] caused the transportation of Indian surrogates to Nepal and Thailand, where surrogates are further excluded from their communities and no governmental monitoring exists.[48] When these places banned cross-border surrogacy markets,[49] Cambodia became a new destination for Indian surrogates.[50] In addition, Georgia opened an independent cross-border market.[51] Similarly, where a state does not allow egg donation, egg sellers are flown to countries with permissive legislation and brokers bypass the restrictive regulation.[52] Another reaction to abolishing both markets is the rise of black markets.[53]

The complex reality seems to require an international monitoring-regulation that acknowledges some transactions in both egg and surrogacy markets. Should this regulation be different for each market or can both markets be regulated under one model of regulation? To answer this question, the next section reviews market failures that any regulative model should address, based on evidence from studies on both egg and surrogacy cross-border markets.

## II. Market Failures: are the Reasons to Regulate the Cross-border Egg and Surrogacy Markets Different?

Given that some sort of commodification should probably be acknowledged, this section reviews several market failures to find out whether the motives for the regulation rising from egg or surrogacy markets are similar, or if the market failures are different in each market and require different models of regulation.

The market system has its own values and is supported by strong arguments.[54] First, the market helps the development and exercise of our capacities as autonomous individual decision-makers. The market is an instrument that maximizes liberty and freedoms: the freedom to transact, negotiate terms, and make a personal judgment about what to buy or sell, all of which nurture conditions for self-esteem.[55] Second, the market efficiently "constructs social coordination among independent individuals with diverse values and preferences through contracts."[56] In such economic transactions all parties can benefit from the market and therefore possess a mutual interest in the transaction.[57] According to the neo-liberal principle of state neutrality, in a modern economy any state policy decision, whether restrictive or permissive, interfering with choices made by adults who freely consented to a transaction, is considered objectionable. Meaning, according the neo-liberal principle of state neutrality, state interference is unjustifiable unless the market results in market failures that need to be corrected.[58]

Known market failures are externalities that occur when one benefits without anyone taking responsibility for financing the benefit or without paying for minimizing damages that follow.[59] Externalities are almost inherent in the context of cross-border markets where no international regulations exist. Inside a consumer states' territory, the provision of reproductive services is—directly or indirectly—subject to state regulation, either through

health policy or, if such services can be traded in the market, through contract law, which subjects the market's participants to certain duties of justice. States should regulate the terms of provision for reproductive services and establish proper medical standards. If reproductive services are nationally provided, states should secure a fair distribution of access to those services. Alternatively, if reproductive services are primarily distributed through the market, either privately or via insurance coverage, then states should regulate that market so as to ensure that no woman suffers exploitation or infringement of her rights. Additionally, doctors owe their patients a duty to give medical treatment that comports with the minimum standard of care. When doctors breach this duty and patients are harmed, patients can sue doctors for malpractice or other civil liability in state court to recover damages.[60]

However, in era of globalization, the ease of mobility, professional training, and information and service availability has facilitated citizens' private access to safe extraterritorial reproductive markets. Neither consumers' nor women's states, nor their institutions are a party to these private contracts in the free market.[61] In other countries, consumers' states do not determine the rules governing transactions. No binding legal norm obligates consumers' countries to either promote the fairness of their citizens' private transactions or to prevent the exploitation of assisting women who are citizens of other countries. To that degree, consumers' states are not legally obligated to secure the justice of these transactions as they probably would be with respect to transactions that occur exclusively between domestic parties.[62] Transactions are conducted according to the laws in the destination countries where they are carried out and are monitored differently in each state. Consumers may sue for malpractice, but it might be difficult for them to prevail on their malpractice claim in foreign countries because the specifics of malpractice laws are often not readily available to them.[63] Different legal systems, language barriers, cultural differences, and travel costs might be an additional obstacle.[64] The lack of clear standards or coherent international regulations means that cross-border markets facilitate externalities.

An efficient and fair allocation of benefits depends on equal bargaining power and free choice.[65] However, in the cross-border market, when bargaining power is unequal, people use the market to gain an unfair advantage, and challenge the element of effective distribution of risks and benefits.[66] In both egg and surrogacy markets, women's impoverished position is reflected in the cross-border reproductive markets. The next section reviews several market failures in both cross-border egg and surrogacy markets in lower-middle income countries: a questionable process to get informed consent, the violation of women's health rights, improper medical standards, exploitative contracts and under-recognition. If certain characteristics are severe in one market but not the other, different regulative approaches will be justified. But if market failures raise similar concerns, there is no real reason to call for the regulation of just one market, or to regulate cross-border egg markets differently from surrogacy markets.

### a. Market Compromises Autonomy - Informed Consent and Decision-making

Any medical procedure, in particular one that entails the medical risks discussed above, requires a women's informed consent, which should be given after delivering her accurate information about the risks. Unfortunately, both markets raise concerns about information

inadequacies, challenging the justifications that support permitting the market: maximization of autonomy and efficient distribution. In egg sales, the omission of information is structural, meaning the interest not to disclose all information is inherent to the practice.[67] Some argue that physicians are under an inherent conflict of interest: doctors want to maximize the opportunity to create more embryos by retrieving as many eggs as possible, but they are committed to the best interests of all patients, including those of the egg seller.[68] Concerns have been raised that "physicians are not fully cognizant of this conflict because they don't view the egg donor as a patient,"[69] and thus compromise her best interests. Others claim that the medical risks of the procedures for egg harvesting are largely unknown.[70]

The reports on surrogacy cases from India paint a similar picture. When procedures are carried out across borders in low-middle income countries, the incentive to provide such information may be low and the legal demand for informed consent seems to be somewhat fluid.[71] Often, consent forms do not provide all of the required information and put women at a disadvantage.[72] Additionally, the known risks are measured in good healthcare systems that may eliminate many of the risks created by inadequate facilities.[73] In countries with less-developed healthcare systems, the risks are likely to be higher due to less access to safe, sanitary healthcare facilities.[74] Furthermore, for surrogates who do not read English, the translation of the consent form may not provide adequate information that should be a basis to a voluntary and informed consent.[75] When, due to insufficient information, women are unaware of the risks they are consenting to or do not understand the medical and legal procedures involved, they might fail to estimate the value of the contract, and their consent may not be truly informed. From a medical ethics and liberal legal standpoint, this situation does not constitute a truly autonomous choice.[76] Information inadequacies or lack of transparency are a market failure that have legal and economic consequences, not only for surrogates, but also for intended parents. Intended parents may also suffer from lack of transparency and be asked to pay additional payment for every action that is not previously mentioned in the contract (such as, meeting the surrogate, or additional medical exams).

Insufficient informed consent further compromises health rights.[77] Persons that lack knowledge are ill positioned to challenge the false of information given to them by mediators and clinics, thus they are weaker parties in the transaction. The impoverishment of women leads to disrespect and a lower medical standard during procedures. For example, according to the Indian Council of Medical Research guidelines, "no more than three oocytes or embryos may be placed in a woman in one treatment, regardless of the procedure/s used, except under exceptional circumstances."[78] Nevertheless, few reports mention the occurrence of transferring five or more healthy embryos back to the surrogate in the pursuit of more profit.[79] This risks higher rates of multiple pregnancies and endangers the woman and the fetuses.[80]

Some argue that cross-border markets rely on particular positions of assisting women in lower-middle-income countries, making them more available for the commercialization of reproductive commodities.[81] Pande argues that the surrogates in Anand are especially attractive not just because they provide cheap services due to economic desperation, but because their vulnerability makes it possible to subject them to further control by the doctor and the consumers.[82] The details of the procedure and its results are not necessarily shared

with the surrogates.[83] For example, one surrogate stated that "when I went in, I was given an injection and told nothing about what they were going to do. Even at home I was not informed that something like this will happen."[84] Surrogates may be forced to terminate the pregnancy if the intended parents desire, and cannot make an independent decision regarding their body, for example, whether to keep the pregnancy or abort.[85] The surrogate is also deprived of any part in deciding how she will relinquish the child.[86] From fear that she might refuse to relinquish the child, the clinic, consumers, and at times mediators make all decisions.[87] Similar disrespect is evident in egg provision cases. Nahman describes a situation she observed in Romania, where the focus was on getting the eggs, and the egg provider seemed to be unnoticed and unattended by the medical staff when she required assistance.[88] She concludes that this is only possible because assisting women are perceived as raw material that serve to create future children for infertile individuals, and as a source of profit for fertility clinics.[89]

A major market failure entailed in lower medical standards and the violation of health rights is the opportunity assisting women have to change their minds. This is a consequential failure for both egg and surrogacy markets, given the small window of opportunity available in each procedure. Egg sellers may only withdraw their consent up to the fertilization stage, which occurs within a few hours after egg retrieval.[90] After the egg is fertilized it contains genetic material from at least one other person, and belongs to the intended parents. In surrogacy, during pregnancy, once the embryo is implanted inside her body, a surrogate cannot gain back control even if she withdraws her consent, unless she pays the great physical and emotional price of abortion.[91] It is not easy to "quit the contract." In many countries surrogacy contracts are subject to legal limitations on the possibility of aborting. Moreover, a surrogate may also have to compensate the intended parents for the loss of their genetic embryo and for breach of contract.[92] It is hardly realistic that a surrogate will exercise this right when her motivation to supply reproductive services is financial in nature. These obstacles might make the breach not worthwhile and may force a surrogate to go on with a contract, which, in many other contexts would be considered servitude.[93]

Compromised informed consent and autonomous decision-making are common market failures justifying the regulation of both markets. If we value space for choice and decisions, regulation must ensure that information will be transparent and known to women before and during the period of the contract. Regulations should require easy access to accurate information through public channels.[94] Centralized regulation could provide a single framework that subjects each market to mandatory medical guidelines and regulations that protect basic health and human rights, assure safeguards for medical standards, and minimize extensive control.

### b. Market Compromises Contractual Benefits

Another type of market failure is the unfair distribution of contractual benefits due to the power imbalance between the assisting women and intended parents. In both developed and developing countries, financial incentives seem necessary to engage women in reproductive markets.[95] However, socioeconomic disparity is greater in the context of low-middle income countries.[96] Accordingly, these services are undervalued and underpaid compared to the

same transactions in affluent countries.[97] This is typical in both markets. Egg sales in affluent countries vary from $1,500 to $150,000, with a reported compensation rate of between $4,217 and $5,200 per cycle.[98] In comparison, Romanian transactions valued at $200 pay for approximately 20 eggs.[99] The surrogate's base fee in the United States is between $20,000 and $55,000 in addition to payment for her expenses and other negotiable fees.[100] In India, surrogates receive between $2,500 to $7,000, about 10%-20% of the total amount the intended parents pay the clinic.[101] Different pricing does not necessarily indicate exploitation, since conditions in destination states differ from those in the affluent states. The measurement of fairness is not an absolute evaluation, but a relational one that depends on the context.[102] However, even if lower reimbursement does not necessarily mean that the transaction is unfair, lower protections for extended externalities and increased contractual risks do.[103]

For example, in many United States contracts, the intended parents cover a surrogate's expenses for an independent lawyer.[104] The lawyer ensures that the surrogate receives everything related to her medical condition, and that she is protected from fraud. She receives medical expenses related to the pregnancy, health insurance for her and her family for the entire pregnancy, and expenses—including maternity care and clothing.[105] She also has the privilege of choosing her clients (the intended parents).[106] In India these norms do not apply. The contracts usually regulate issues directly related to the fetus. Surrogacy contracts address issues of compensation, the type of procedure, psychological testing, psychiatric evaluation of the surrogate, and how many times the surrogate can attempt surrogacy.[107] They emphasize that the surrogate has no genetic connection to the children and that she will relinquish the child (a healthy child[108]) and any right to it immediately after birth.[109] It does not stipulate any conditions governing the surrogate's well-being with respect to health insurance coverage, nor does it establish an allocation of responsibility in the event of complications or death during or as a result of the pregnancy.[110] The surrogates' future after the process ends (medical and social) is uninsured by the contract, even though some surrogates are not accepted back by their families.[111]

Such detailed information is not available on egg donation. Rather, the literature shows that even in domestic egg markets, there are many compromises on contract protections of egg providers.[112] For example, Andrea L. Kalfoglou and Gail Geller mention a case where clinics did not inform providers that they faced the risk of hyper-stimulation and "women were billed for medical expenses for follow-up care and medical complications, even though both were promised that the clinic would cover these costs."[113]

Regulation could intervene to encourage the operation of healthy, fair competitive markets, demanding, for example, a separate medical professional to care for assisting women, proper insurance etc., as discussed below in section IV(a). A single model of regulation could coordinate the market and assign a division of liability among participants that reflects their responsibilities, powers and capacities in the market--thereby safeguarding the interests of all participants.

### c. A Market Compromises Recognition

The market interfaces not only with economic dimensions, but also with other social and personal dimensions that are currently harmed and should be addressed by regulation. Where the market is dominant, commodities mediate membership and recognition.[114] Recognition is a function of norms of appreciation, which depends upon a moral understanding of persons and their positions. Recognition is neither a personal attribute dependent on self-will nor is it necessarily universal. Rather, it is concerned with the institutionalized cultural patterns of acceptance, appreciation and valuation of people's contribution.[115] Recognition is a condition for full human flourishing in a society that forms and defines people's identities as individuals. Therefore, recognition is necessary for seizing opportunities, and underlies individuals' self-esteem, which is achieved through participation in the market, among other structures.[116] Indeed, egg recruitment and carrying a pregnancy to term involve different efforts, thus may entail different moral understandings of surrogates and egg providers and their social positions. Should egg providers and surrogates be differentially recognized?

The current operation of both markets reflects the power imbalance whereby the contributions, needs and interests of both egg providers and surrogates are undervalued and their agency is often under-recognized. For example, in lower-middle income countries, surrogates cannot choose their "clients" or the terms of connections with them— rights that women in countries like the United States have.[117] While the intended parents can choose the profile of their surrogate,[118] the identity of the intended family is not disclosed to surrogates to decide whether to enter the transaction.[119] The surrogates may meet the intended parents for the first time when they sign the contract, at which point they lack a meaningful choice.[120] After birth, especially in cross-border transactions, surrogates have limited connection to the parents and usually no shared experience with the child, unless the parents choose otherwise.[121] Similarly, egg providers usually do not meet the recipients or choose the profile of people who will eventually raise their genetic offspring.[122] Guidelines often state that "once the donation has taken place, the recipient retains all rights over the disposition of the embryos,"[123] so the provider does not have a relationship with the future child. The lack of recognition or appreciation may be an important component for women when deciding whether to participate in such a contract. Recognition is reciprocal in character.[124] When people cooperate, but one is appreciated and the other treated as disposable or invisible, the latter is under-recognized.[125]

Both egg and surrogacy markets raise a common need for a regulative model. The cross-border reproductive market harms assisting women because they are treated as socially inferior to others. When class power dominates a market, recognition is unjustly distorted, resulting in disrespected groups who internalize lower social esteem.[126] It influences the way those women perceive and think about themselves. Egg sellers acknowledge socioeconomic disparities between them and the consumers: "unfortunately, the eggs are going to people who can afford to buy them, rather than to poor people."[127] Similarly, a surrogate's narrative expresses her disposability:

> The couple and the family had become like a family to me. They treated me very well throughout the pregnancy. But on the day of the delivery their [behavior]

> started changing. First they were reluctant to let me see the baby. When the nurses brought her over to me, [the intended mother] started instructing the nurse to give me pills, to stop my breast milk! I had just delivered her baby and all she could think of is that I should not be allowed to feed the baby![128]

The under-valuation of assisting women's contribution exacerbates under-recognition and disempowerment of women in the market. It aggravates women's lower social position as third-world women and their internalization of their marginalized gendered class.[129] This further diminish their recognition as agents in the market and shapes the way an entire class is perceived by others. In these cases, market mechanisms fail to produce results consistent with the public interest.[130]

Under-recognizing women's agency results in stigma. Economic, religious, or political conditions intensify stereotypical conceptions and shape beliefs about the female role in society.[131] As a consequence, some women—egg providers and surrogates—report that they do not reveal their occupation to family and friends.[132] Some surrogates in India tell their neighbors that "they gave away their child or that the baby died."[133] Some egg sellers in Romania refrain from telling the families they have undergone the procedure, either to assert their own authority over their bodies or because they are ashamed.[134] For example, egg provider Elena explains: "I feel shame to win the money in this way. I believe it's not a help for me, because I don't really work for this money. I prefer to work for this money, but in this case it came and it was easy. It's like a weakness."[135] Although stigma is not necessarily an indication of a market failure, it is still a direct consequence of lack of recognition of women in the reproductive markets.[136] Stigma might attach differently to egg recruitment, which is not physically visible in the way that pregnancy is and egg providers may face less stigma than surrogates.

Additionally, both markets result in discrimination, the kind often disregarded by the state and raises a violation of the right not to be discriminated against. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (art. 2) requires the state to take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise.[137] The Universal Declaration on Bioethics and Human Rights, adopted within the United Nations Educational, Scientific and Cultural Organization (UNESCO declaration) (art. 11) states that no individual or group shall be discriminated against or stigmatized on any grounds, in violation of human dignity, human rights and fundamental freedoms.[138] Often, states are not in compliance with their duties to protect these women against discrimination, and women's inferior position created by that discrimination is not addressed. Regulation should acknowledge conditions of inequality and aspire to contribute to the development and recognition of all involved, even those coming from unequal backgrounds. Regulation should correct the conduct of the market and focus on recognition of persons and their market positions and contributions.

To conclude, it seems that the regulation of cross-border egg and surrogacy markets finds justification from a combination of rationales. One stems from the acknowledgement of asymmetry in bargaining positions had the intervention not taken place.[139] A second stems from market failures, externalities and evidence of exploitative practices. A third reflects the

need to enhance societal recognition of market participants. Even though these justifications apply to both markets, currently only the surrogacy market encourages initiatives for regulation.

## III. The Different Interests in Cross-Border Egg and Surrogacy Regulation

This section considers why there is more pressure to regulate surrogacy markets rather than egg markets. Initiatives for regulation usually stem from the intended parents' countries—most of which restrict domestic transactions of this sort—who are not the obvious duty bearers in cross-border markets.[140] Assisting women's states are the naturally responsible authority for amending injustices stemming from transactions that are signed and executed in their jurisdiction, place their citizens in physical risk, and bear the potential to infringe citizens' rights.[141] These states have the domestic prerogative to minimize the negative effects on their citizens and ensure the implementation of human rights within their territory.

Despite this power, the initiative for international regulation comes from the home country of the intended parents because the home country must register their citizens' children born through surrogacy markets. In cross-border transactions, the legal parenthood of intended parents is either established in the state of birth, since most countries automatically give parenthood to the woman giving birth,[142] and then confirmed by the consumers' state, or must be acquired when parents return to their home country.[143] In order to find a practical solution to children appearing at their border, consumers' states acknowledge the consequences of market transactions and register children born through the cross-border surrogacy transactions, even if, domestically, such transactions would be considered illegitimate.[144] Countries such as the United Kingdom, the Netherlands, Germany, France, and New Zealand ban commercial surrogacy but give citizenship and parental rights to children born from cross-border reproductive transactions.[145] For example, in the United Kingdom, the courts permitted the recognition of children that were born in cross-border transactions despite the "significant" amounts of money parents spend.[146]

The European Court of Human Rights (the "ECHR")'s recent rulings demonstrate that consumers' states might have a duty—not a choice—to register the resulting children.[147] In *Mennesson v. France*, *Labassee v. France*, and *Paradiso and Campanelli v. Italy* , the ECtHR addressed countries' refusal to recognize the parent-child relationships that were legally created through cross-border surrogacy markets, due to insistence to keep national public policy.[148] In the *Mennesson v. France* case, despite a United States judgment acknowledging the parenthood of intended parents, the French authorities refused to register the child.[149] The French court held that registering the child as a French citizen would contradict the principle of inalienability of civil status, and the French Civil Code as a matter of public policy.[150] The parents, brought the case before the ECtHR, arguing that the refusal violates the right to respect for their private and family life (Article 8 of the European Convention on Human Rights), but the court upheld the refusal to acknowledge parents-child relationship on this ground.[151] Nevertheless, different children rights related to privacy and identity were considered justified in order to recognize parent-child relationship established abroad through cross-border surrogacy markets in accordance with the best interest of the child.[152] Similar ruling was given in the case of *Paradiso and Campanelli v. Italy*, whose

circumstances were slightly different.[153] According to the ECtHR ruling, the authorities have an international obligation to protect the best interests of the child that outweighs their obligation to national public policy or even to the minimal demand to ensure surrogates' health rights and safe procedure. This could lead to registration of children even in cases where they are the result of an unethical and risky procedures.

The surrogacy market, which results in living children, yields few initiatives for international regulation surrounding the interests of resulting children and their registration. On a diplomatic level, some states' authorities have attempted to prevent registration difficulties. For example, in 2010, offices of Consuls General representing eight European states jointly authored a cease-and-desist letter to several Indian clinics, demanding that they consult with those states' embassies prior to providing any surrogacy services to their citizens. [154] The United Kingdom took a separate approach and issued guidance for prospective parents which aimed to educate them before starting the surrogacy process.[155] Before Thailand banned provision of surrogacy services to foreigners, the Israel embassy in Bangkok approached the Thai Ministry of Foreign Affairs to inquire about hiring female Thai nationals as surrogate mothers by Israelis.[156] In this way, they could verify the legality of the procedure and ensure that the resulting child could have citizenship. Countries where foreigners come for surrogacy services have also taken action. An Indian Bill attempted to require consumers to show that the resulting child could be recognized as their child by their home state and registered accordingly.[157] The Hague Conference on Private International Law ("HCCH") is currently investigating the prospects of a convention on the regulation of cross-border surrogacy markets, based on the model of international adoption.[158]

Although motives for regulation apply to both markets, no parallel actions exist to regulate the international cross-border egg market,[159] where there is no existing child whose rights may be infringed. The Italian government stated that it banned donor gametes domestically in order to affirm that only heterosexual couples are an appropriate type of family formation, because it feared that approving of homosexual families would cause harm to children and society.[160] Without condemning or supporting this position, the Italian government should have an interest in preventing or reducing such harms regardless of the source of the egg. The wish to affirm that only heterosexual couples are an appropriate type of family formation does not change whether the child is a result of a domestic or foreign gamete. Nevertheless, despite the national concern for potential harms to children and society, the law acknowledges parental rights over children born as a result of cross-border egg transaction.[161]

There was one domestic effort to monitor the cross-border market. In 2009, Romania charged Israeli physicians for trading eggs taken from Romanian women and implanting them in Israeli women.[162] This, however, was a national Romanian action, since trafficking was considered an offense in Romania. The unilateral action did not fuel any international initiative to correct market failures. Moreover, while this case may have had good intentions, it does not remedy cases of cross-border reproductive markets that do not rise to the level of trafficking.

Regulation initiated solely for the sake of facilitating registration of parent-child relations and citizenship does not necessarily support the best interests of assisting women because it is not motivated by consideration of those interests.[163] However, regulations could and should focus more on assisting women, as the two regulative approaches explored below emphasize.

## IV. How to Regulate the Market?

Two possible regulatory models could better serve the interests of assisting women. A minimalist legal-economic model would require a framework to ensure that there are medical, ethical and safety conditions to protect women. By contrast, a more pro-active approach would also address the personal and social implication of under-recognition. Although the following section supports the inclusive pro-active approach, it shows that either approach requires adopting a single regulative framework for both egg and surrogacy markets.

### a. Minimalistic Risk Regulation Model - Standardization and Basic Rights

Providing reproductive services without proper medical care endangers assisting women and the resulting children, and violates their rights. This is an undesirable consequence for assisting women, the child, the intended parents and their countries.[164] Regulation could benefit all participants potentially harmed. A minimalistic risk-regulation model could protect the parties' basic rights and minimize negative implications, whether for egg or surrogacy markets. Such a model would ensure that the market operates according to proper medical standards underwritten by clear professional, medical and safety guidelines for each procedure which ensure that no human rights are violated.

The main concern with respect to the differences between egg and surrogacy markets is in the medical risks involved. But this difference does not require a different regulative model. Medical standards are modular and do not depend on cultural or national values, but rather on evidence based medicine.[165] Existing mechanisms, like professional guidelines and human rights, can provide a benchmark for proper medical standards and informed consent. They could easily be adapted to each medical procedure. For example, a public agency could require and enforce standards for each type of reproductive technology.[166]

To confront socioeconomic disparity, a minimalistic approach could also regulate the price of each procedure and redistribute economic benefits more fairly. Each procedure might have a different price to award assisting women with a compensation reflecting the different physical risk factor in each process. Higher prices could fairly compensate women for greater risks and inconveniences.[167] Differential pricing may change the potential profitability of the contract and represent society's position regarding fair terms and its commitment to ensuring that the transaction benefits all.[168] This justifies one regulative model, adapted to each technology.

As discussed above, in section II (c), the problem of transactions involving reproductive services is wider than that of poor medical or ethical standards, and is embedded in a structurally unjust system. Although a higher compensation might be a fair distribution

under a minimalistic regulative model, increased payment in itself does not constitute recognition.[169] A woman deserves payment for fulfilling the contract. The contract determines what is owed to her, but not the recognition she deserves, which is connected to what people deserve prior to entering the contract. Thus, a minimalist approach might not address this aspect. This supports the claim that fair redistribution and establishing recognition for assisting women should be interconnected.[170] Addressing the wider recognition aspect requires a structural, rather than a minimalistic approach.

### b. Pro-active model - Recognition

A pro-active regulation model could revalue groups with diminished recognition and foster desirable market relations that are sensitive to social needs.[171] What does recognition mean for women in each practice? Evidence shows that egg providers and surrogates each value the service they perform and have certain expectations due to their contribution.

Kalfoglou and Geller show that egg providers "expect to have more control over the donation process and distribution of their oocytes."[172] Women want to know what happens with the eggs that they provide—whether an embryo was created, frozen, discarded, used for research, donated to additional women—and are concerned that the parents will not meet her specifications for acceptable recipients.[173] Their follow-up study with egg providers in the U.S. reveals that egg providers expect a certain level of control over the decision of who are the parents who will raise the child born from their egg:

> I want to know where it's going. I'm not just haphazardly giving out eggs because that child is going to walk around with my eyes, my nose, my hair, and I want them to be treated well and raised with respect and at least in the manner in which I could have provided.[174]

They also want to know how many genetically-related children were born from their eggs, to protect their children from having sexual relations with half siblings, or protect themselves in case the children try to contact them later in life.[175] Egg providers mention feeling left out when they received no information or that they "felt like a failure" when not contacted again.[176]

While the procedures themselves and the role that women play in them are different, the surrogate may also feel that she is *entitled to* make claims on the baby. The effort she has put in gestation and giving birth makes her deserve a certain amount of recognition.[177] For example, surrogates in India told researchers about their experience:

> They [doctors] only talk to the family [commissioning parents], as if it is them and not us who are pregnant.[178]

> After the delivery both the children had been admitted since it was a premature birth they were under supervision. I heard she (commissioning mother) sat with them all day but she didn't come to see me even once. I was told the next day to leave. She came to meet me before I left. I asked her why are you sending me away so soon? She said it's better if you leave now. This time we will not repeat our mistakes. **We will not sign on a wrong agreement. And we will ask to see the**

> **child. We will tell them to call after taking the child**. But no one is ready to do that, they are very much concerned that the child should not get to know.[179]

As these examples show, surrogates often feel under-valued or disposable and wish that their role in the surrogacy procedure would be acknowledged. Resulting children may also feel dissatisfied with this disconnection.[180] Different blogs describe feelings of rejection by assisting women. The children also mention feeling a loss of identity and discuss how important it is for them to know the assisting women, despite their rearing parents' feelings.[181]

A moderate form of recognition could acknowledge certain legal rights of assisting women, grant them legal entitlements for more extensive information about the resulting children and further control within the transaction. Egg recruitment and pregnancy-carrying to term involve different efforts and connectedness. Recognizing women's role and entitlements could reflect this difference. Both kinds of assisting women could, for example, choose the profile of intended parents, with the possibility of refusing consent or withdrawing from a certain profile. Egg sellers could also specify how many people would receive their eggs and what would happen to the fertilized eggs if the recipient no longer needed them for reproductive purposes. Both kinds of assisting women could receive general information regarding the child's well-being, if they so wished.[182] The different rights of resulting children should be relative to those of the assisting women. Because children should have a right to obtain information about their origin, assisting women may be required to disclose —albeit anonymously—certain information in the future. For example, egg providers may have a duty to provide genetic information when genetic origin has medical implication. Duties and entitlements of assisting women should relate to their distinctive contribution and should not be equivalent to those of the intended parents, who will be the child's raising parents and as such should receive the traditional rights and obligations associated with that role. The parents committed to rearing the child—the intended parents—should be the only ones required to support the child and take care of him or her.

John A. Robertson mentions a stronger need for recognition that the egg providers have—to participate in the child-rearing process.[183] Although some evidence for this interest exists in egg donation,[184] stronger evidence exists in surrogacy studies. Interviews with surrogates show that surrogates expect a long-term relationship to compensate for the gift they are giving.[185] The relationship expected is similar to friendship or family ties, which they rarely receive. The market's current operation does not satisfy these interests.[186] State power plays a crucial role in excluding egg providers and surrogates from the intended family when it determines which relationships to recognize. Generally, where regulated, the different biological or genetic connections gamete sellers' and surrogates' have to the child are both unrecognized in the legal system.[187]

A more extreme form of regulation could therefore consider a familial structure enabling interested families to involve assisting women in the child's life in some way. Regulation could extend visiting rights or allow non-anonymous egg provision.[188] Many intended parents may see such an arrangement as a deal breaker. From a market point of view, viewing gametes and surrogacy services as market commodities implies that assisting

women provide a product, raw material, or a service to interested consumers. The payment is seen as completion of the transaction, after which the relationship with the assisting woman is not expected to continue, especially when parties are from two different countries.[189] But, maintaining respectful and inclusive relations might be a social interest, or value, that endures beyond a single transaction. Moreover, because of a child's independent claim and possible interest in knowing her origins, recognizing assisting women is part of the obligations that intended parents owe their children.[190] With many new types of families, this could be a realistic option if the contract clarifies these matters.

If this is what recognition means, then maybe policy-makers should abolish the market unless recognition of assisting women is integrated into it. If social relations matter, a market that recognizes assisting women should be allowed, and one that is not should be prohibited. Despite differences in how recognition would apply to each practice, the regulative model of both markets should establish a platform that includes, empowers, and recognizes all participants, including assisting women. The choice to use the aid of an assisting woman, or to provide such aid through the cross-border market in human reproductive assistance generates a certain path for both parties. Choosing this path may impose upon participants a duty to recognize and respect each other. The need to respect your fellows, to recognize those who assist you through the market as human beings, should not only be a response to market failures. Rather, the demand that all persons in society be respected, as such, should be the foundation on which we establish the mechanism of the market.[191] Alternatively, the desire to remain connected may vary among assisting women, and some women may prefer to stay anonymous and disconnected.[192] The current practice disconnects by default all assisting women from the family of the resulting child, including those who long for recognition. This situation increases alienation and exclusion of those who expect otherwise. A regulatory model supporting the recognition of assisting women's concerns should at least offer the possibility of a flexible transaction in both egg and surrogacy markets.

## V. Conclusion

The negative implications of the cross-border reproductive market do not stem from one transaction, but from the way that the market structure strengthens preexisting vulnerabilities, and reaffirms the hierarchical relationships. Social contexts that constitute a gendered socioeconomic class continue to keep some classes in a disempowered position. In the current cross-border framework, various health rights and basic freedoms of assisting women are infringed or violated, decreasing their recognition in society. The occurrence of medical risks, emotional burden, stigma, and biological and genetic connections to the resulting child may be different, but the implications are similar in both markets. Each market suffers from low medical standards, questionable process of informed consent, decreased protection of human rights, and a disparity in contractual benefits. In both egg and surrogacy markets, these considerations affect the way that assisting women perceive themselves and how they are perceived by society.

The fact that cross-border surrogacy creates stronger pressure for international regulation than egg markets is taken to imply that these technologies call for distinct sets of regulations. This inference is mistaken. The distinction between regulation of cross-border egg and

surrogacy markets diverts the focus from assisting women to intended parents and children. It leads to a minimal regulation of safety and medical technical conditions rather than a comprehensive regulation addressing the recognition of all involved.

Despite obvious differences between providing egg and uterus services, a wider common ground exists between the two markets that policy-makers could address through one regulative approach. A pro-active model of regulation could contribute to social recognition, empowerment and respect, as well as minimal human rights and safety conditions. Disregarding these similarities may deprive assisting women from receiving the recognition they deserve.

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75. Pande 2009, *supra* note 28, at 147; Social Research, *supra* note 36, at 41 (reporting that 51.7% of the surrogate mothers in Anand were illiterate); Sama–Resource Group for Women and Health, Birthing A Market: A Study on Commercial Surrogacy. :40.2012*available at*http://www.communityhealth.in/~commun26/wiki/images/e/e8/Sama_Birthing_A_Market.pdf[hereinafter SAMA].
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80. Donchin, *supra* note 78, at, 328; Saravanan, *supra* note 10, at 8; Social Research, *supra* note 36, at 44; SAMA, *supra* note 75, at 66.
81. For egg market *see*, Nahman, *supra* note 19 (arguing that "privatized transnational oocyte traffic relies on such global inequalities"); for surrogacy market *see* Qadeer, *supra* note 72, at 29 (arguing that the medical profession can be accused of supporting the inequality of power by using needy women).
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83. SAMA, *supra* note 75, at 63–69.
84. SAMA, *supra* note 75, at 62 SP3's interview.
85. Qadeer, *supra* note 72, at 31; Social Research, *supra* note 36, at 5, 29, 45, 78 (the decision regarding the continuation of pregnancy in cases of an abnormality is rarely taken with the surrogate (only 2.9% of respondents in Surat had a say), and usually includes only the clinic and the intended parents).
86. Social Research, *supra* note 36, at 75.

87. *Id.* at 66.
88. Nahman, *supra* note 19 (“There’s no heart monitor, as there were in other Israeli clinics. She just gets an injection of white liquid in the arm and an intravenous drip… they still cannot get the machine to work. Finally they call in Nakhum to help. The young egg donor is still lying asleep. No one is checking that she is still breathing. Ten minutes go by; they are still focused around a machine… Now the young woman is waking up – no one notices. When they do notice they tell her to lie still. She talks and they ignore her. The egg-donor-in-waiting sits up – grabs the doctor and makes her pay attention gently. But they are still fiddling with the aspirator. The patient gets up. The doctor says, ‘stai a coloputsin’ (translated from Romanian: ‘stay there a little’) to gently calm her.”).
89. *Id.*
90. [last visited Mar. 31, 2018] Advanced Fertility Ctr. Of Chicago. https://www.advancedfertility.com/aspiration.htm
91. *See* Satz 2010, *supra* note 41, at 132.
92. Qadeer, *supra* note 72, at 30 (reporting “cases of the surrogate refusing to part with the baby, but being unable to pay back the sum received”).
93. *See* Allen, *supra* note 41, at 142. *See also*Feinberg, Joel. Harm to self: The Moral Limits of Criminal Law. :80–81.1986(warning against recognizing slavery contracts, which might send a message of indifference towards society, implying that it abandons reckless members who choose to enter these contracts. This could lead to a general decrease of care and compassion in society.).
94. Baldwin, Cave & Martin, *supra* note 65, at 19.
95. *See*Wilkinson, Stephen. Exploitation in International Paid Surrogacy Arrangements. 33J. of Applied Philosophy. :125, 129.2016;
96. On financial incentives in the recruitment of egg providers, *see* The Ethics Committee, American Society for Reproductive Medicine, Financial Incentives in Recruitment of Oocyte Donors. 82Fertil. & Steril. (suppl. 1):S240, S240.2004; [PubMed: 15363740] [hereinafter The Ethics Committee]; On financial incentives in the recruitment of surrogates, *see* sources cited *supra* note 28.
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101. Saravanan, *supra* note 10, at 11 (reporting that the highest payment made to a surrogate was $9,724. The particular consumer wanted to pay more, but the doctor refused. “This could prompt such demands and unnecessarily raise expectations from other surrogate mothers as well.”).
102. Bassan, 2016, *supra* note 77.
103. *See* The Economist, *supra* note 44.
104. Qadeer, *supra* note 72, at 29–30.
105. *Id.*

106. *See, e.g*Surrogate Mother Program. The Surrogacy. last visited April 1, 2014http://www.thesurrogacysource.com/sg_about.htm("you will be presented with profiles to select your intended parents, you will meet with our staff and intended parents to make sure that this is the right couple for you.").
107. Social Research, *supra* note 36, at 43–44.
108. Bassan, Sharon. Fair Trade as an Instrument for the Regulation of Risk in the Cross-Border Surrogacy Market. 4EJRR. :750, 753.2016; [hereinafter Bassan, *Fair Trade*]; Social Research, *supra* note 36, at 5, 29 (mentioning cases in which couples refused to take a baby of a specific sex, or when a defective baby was born and they filed suit against the surrogate arguing she had broken the contract); SAMA, *supra* note 75, at 107.
109. Social Research, *supra* note 36, at 43–44.
110. Qadeer, *supra* note 72, at 31; SAMA, *supra* note 75, at 93. Williams, Holly. India's Surrogate Mothers Exploited? CBSNews. Apr 11.2013 http://www.cbsnews.com/video/watch/?id=50144661n(telling the story of a surrogate, mother of two, who died due to complications. Her contract had no clause to protect her and her children from such risk.).
111. Saravanan, *supra* note 10, at 9 ("very little social and psychological support was given to the surrogates in the clinic, leaving them feeling miserable post-relinquishment."); Social Research, *supra* note 36, at 76; SAMA, *supra* note 75, at 71.
112. Vera, *supra* note 59 at 391; Kalfoglou 2000, *supra* note 67.
113. Kalfoglou 2000, *supra* note 67, at 231, 236.
114. Walzer, *supra* note 2, at 106. On recognition, *see id*. at chap. 11; Honneth, Axel. Recognition and Justice Outline of a Plural Theory of Justice. 47ActaSociologica. :351, 351.2004;
115. Daniels, Norman. Just Health: Meeting Health Needs Fairly. :56.2008(connecting recognition and justice, since public recognition establishes a public basis for viewing others as worthy of respect, and thus supports self-respect).
116. On self-esteem and self-respect, *see* Walzer, *supra* note 2, at 272–80.
117. E.g., Surrogates Can Choose Their Intended Parents. Extraordinary Conception. https://www.extraconceptions.com/surrogates-can-choose-their-intended-parents/
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119. Social Research, *supra* note 36, at 35 (46% of the surrogate mothers knew the intended parents only by face and name. Nevertheless, due to language barriers and the constant presence of the medical staff there was never any one-to-one communication between the two parties, and the relationship, although harmonious, remained distant.); SAMA, *supra* note 75, at 45. Rabinowitz, *supra* note 48.
120. Social Research, *supra note* 36, at 35; SAMA, supra note 75, at 100 (reporting a case where the surrogate was told she would not be allowed to meet the consumers throughout the entire process).
121. Saravanan, *supra* note 10, at 9.
122. *See*Kramer, Wendy. DNA=Donors Not Anonymous. Huffington Post. Nov 25.2015 https://www.huffingtonpost.com/wendy-kramer/dna-donors-not-anonymous_1_b_8646164.html
123. Kalfoglou, Andrea L; Geller, Gail. A Follow-up Study with Oocyte Donors Exploring Their Experiences, Knowledge, and Attitudes About the Use of Their Oocytes and the Outcome of the Donation. 74Fertil. Steril. :660, 666.2000; [PubMed: 11020503]
124. *See*Taylor, Charles. The Politics of Recognition. New Contexts of Canadian Criticism. :98, 112.Heble, Ajay; , et al.1997(exploring reciprocal aspects of recognition through Rousseau's theory).
125. Shaw, Joshua. What Do Gestational Mothers Deserve? Ethical Theory and Moral Practice. :1, 3.2016("there is something *ungrateful* about dismissing gestational mothers from considerations involving the wellbeing of children they have carried to term given *the effort* involved in pregnancy.").

126. Satz 1992, *supra* note 41, at 94. *See* Walzer, *supra* note 2, at 258–59 (suggesting that it does not necessarily have to be the case).
127. *Id.* at 73; *see also* SAMA, *supra* note 75, at 106.
128. Pande, Amrita. Ph.D. dissertation. University of Massachusetts; Amherst: May, 2010 Commercial Surrogacy in India: Nine Months of Labor?; 219
129. Satz 2010, *supra* note 41, at 130; Allen, *supra* note 41, at 148 (expressing concerns that minority women will become the "surrogate class"). *Compare*Pande, Amrita. Transnational Commercial Surrogacy in India: Gifts for Global Sisters? 23Reprod. Biomed. Online. :618, 623, 24.2011; [PubMed: 21958916] (showing how words used by surrogates shed light on the inequities inherent to the structure by indicating their feeling of 'gratefulness' at the attempts of the couple to build a relationship with them despite these differences) *with*Ragone, Helena. Surrogate Mothers: Conception In The Heart. :54.1994(noting that surrogates in developed countries often do not perceive the class difference between them and the couple as significant). Similar observations were made regarding egg providers in Romania, who distanced themselves from the clinic and from intended parents both socially and economically.
130. *Cf*Cohen, Lawrence. Where It Hurts: Indian Material for an Ethics of Organ Transplantation. Daedalus. :135, 148.1999 [PubMed: 11645873] (showing that in areas in India where kidney selling is relatively common, creditors place additional pressures on those who owe them money). This demonstrates the possibility of the market reaching an optimal point. It might be that without the market, people who did not want to sell their organs would not have felt obligated to do so. Opening this choice for the poor will affect those who do not want to participate in such markets.
131. For the reasons for the stigma in India, especially equating it with sex, *see* Pande 2009 *supra* note 28, at 154–55 (explaining that in addition to the common stigma involved with surrogacy (of getting pregnant for money, which is associated with the 'immoral' commercialization of motherhood) there are cultural and social explanations for the stigma: surrogacy entails giving away the baby as soon as it is born, reiterates the disposability of these 'desperate' women, and emphasizes the 'unnatural' nature of their motherhood; surrogates are portrayed in the media as having some kind of 'relation' (sexual or emotional) with the intended father. Many Indians equate surrogacy with sex work.).
132. *See*Surrogacy Still Stigmatized, Though Attitudes Changing Among Younger Women. Science Daily. Jul 7.2008 https://www.sciencedaily.com/releases/2008/07/080706194247.htm
133. *Id.* at 150. *E.g. id.*at 154 (reporting that all the surrogates in her study except one decided to keep their surrogacy a secret from their communities, villages and, very often, from their parents. They usually hid in the clinic or took temporary accommodation away from their communities during the last months of pregnancy. Some decided to tell their neighbors that the babies were their own and later say that they had miscarried.); Qadeer, *supra* note 72, at 30; Social Research, *supra* note 36, at 52, 61 (more than half of the surrogates in the research said that they did not want to admit they were surrogates because of the stigma, so they stayed away during pregnancy); *id* .at 57 (surrogates consider the secrecy to be the worst part of the process); SAMA, *supra* note 75, at 122; Haworth, Abigail. Surrogate Mothers: Womb for Rent. Marie Claire. Jul 29.2007 http://www.marieclaire.com/world-reports/news/surrogate-mothers-india?click=main_sr
134. Nahman, 2008, *supra* note 99, at 72 ("I feel shame to win the money in this way"); Nahman, *supra* note 19, at 629.
135. Nahman, 2008 *supra* note 99, at 72.
136. Wertheimer, *supra* note 66, at106 (arguing that the way a practice is regarded by the society does not necessarily mean that we should condemn the practice. It could be a reason to condemn society's reaction.).
137. United Nations, Treaty Series. Dec 18, 1979 UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women; 124913
138. UNESCO. Universal Declaration on Bioethics and Human Rights. 2005
139. Bassan, Sharon. Shared Responsibility Regulation Model for Cross-Border Reproductive Transactions. 37Mich. J. Int'l. :229, 335.2016;
140. For establishing such a responsibility for consumer countries, *see* Bassan *Shared Responsibility supra* note 139, at 321.

141. Bassan, *Fair Trade, supra* note 108, at 755.
142. For exceptions, *see* Codigo Civil [CC] [Civil Code] art. 347, Diario Oficial de la Federation [DOF] 14-05-1928, ultimas reformas DOF 13-04-2007 (Mex.); for Ukraine *see*, Family Code of Ukraine art. 123(2); Smerdon, Usha Rengachary. India. International Surrogacy Arrangements: Legal Regulation at the International Level. 193Trimmings, Katarina; Beaumont, Paul2013; (stating that the intended mother is considered to be the legal mother).
143. Trimmings & Beaumont, *supra* note 53, at 504.
144. *Id.* at 514–18.
145. For England *see* Human Fertilisation and Embryology Act, 2008, c. 22, § 54(8) (Eng.); Embryonenschutzgesetz [ESchG] [The Embryo Protection Act] Dec. 13, 1990, art. 1(1), No.1 & 2 (Ger.); for the Netherlands, *see* Artikel 151b lid 1A SR. and Artikel 273f lid 4 SR.; for New Zealand, *see* Human Assisted Reproductive Technology Act 2004 § 14(3) (N.Z.); for France, *see* Loi 94-653 du 29 juillet 1994 de Code Penal [Law 94-653 of July 29, 1994 of Penal Code] art. 227-12, Journal Officiel de la République Française [J.O.] [Official Gazette of France], Sept. 19, 2000.
146. Human Fertilisation and Embryology Act, 2008, c. 22, § 54(8) (Eng.) enables courts to consider whether no money or other benefit (other than for expenses reasonably incurred) has been given or received by either of the applicants when authorizing a parental order. *See*Campbell, Denis. Couples Who Pay Surrogate Mothers Could Lose Right to Raise the Child. The guardian. Apr 5.2010 http://www.guardian.co.uk/uk/2010/apr/05/surrogacy-parents-ivf
147. *See*Bassan, Sharon. Cross-Border Surrogacy Transactions (Cbst): Can Consumers' States Choose Whether Or Not to Regulate? Volkerrechtsblog. Jul 20.2016 http://voelkerrechtsblog.org/cross-border-surrogacy-transactions-cbst/
148. Mennesson v. France, App. No.. 65192/11, Judgment 26 June 2014. Judgment of the Fifth Section of the European Court of Human Rights; Labassee v. France, App.No. 65941/11, Judgment 26 June 2014. Judgment of the Fifth Section of the European Court of Human Rights. The same judges as in the Mennesson case but the judgment is unavailable in English; Paradiso and Campanelli v. Italy, App. No.. 25358/12 Judgment 27 January 2015. Judgment of the Twelfth Section of the European Court of Human Rights. Unavailable in English.
149. Mennesson v. France, App. No. 65192/11, Judgment 26 June 2014. Judgment of the Fifth Section of the European Court of Human Rights.
150. *Id.*
151. *Id.* the Mennessons' and the Labassees' applications were jointly lodged and discussed.
152. *Id.* at para. 99.
153. The case of *Paradiso* was different from the *Mennesson* case, in the sense that the child concerned was genetically unrelated to either of the intended parents. The Italian authorities addressed it as international adoption case rather than a cross-border surrogacy transaction.
154. IVF Centres Direct Foreigners to Consulates over Surrogacy Issue. Hindustantimes. Jul 15, 2010. www.hindustantimes.com/India-news/Mumbai/IVF-centres-direct-foreigners-to-consulates-over-surrogacy-issue/Article1-572534.aspx
155. [last updated June 26, 2014] Foreign & Commonwealth Office, Surrogacy Overseas. *available at*https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324487/Surrogacy_overseas__updated_June_14_.pdf
156. Thailand Bans Commercial Surrogacy, *supra* note 49 and Letter no. 1403/2756 from Ministry of Foreign Affairs, Bangkok, to the Embassy of Israel, Bangkok (Dec. 12, 2013) (on file with the author) (clarifying that the law grants Thai citizenship to any child born to a Thai mother. Additionally, the letter states that Thailand does not yet have specific regulation on this issue, but an act that had recently been drafted explicitly prohibited commercial surrogacy. Therefore, at that time the Thai position neither supported nor encouraged the phenomenon and considered it in contravention of the Thai Anti Human Trafficking Act B.E. 2551 (2008).).
157. Indian Council of Medical Research. The Assisted Reproductive Technologies (Regulation) Bill. Ministry of Health & Family Welfare; India: 2010. *available at*http://icmr.nic.in/guide/ART%20REGULATION%20Draft%20Bill1.pdf

158. [last visited Sept. 2, 2014] Hague Conference on Private International Law. https://www.hcch.net/en/projects/legislative-projects/parentage-surrogacy
159. Shalev, Carmel; Werner-Felmayer, Gabriela. Patterns of Globalized Reproduction: Egg Cells Regulation in Israel and Austria. 15Israel J. Health Pol'y Res. :1, 8.2012;
160. Storrow, *supra* note 72, at 306–307.
161. Storrow, *supra* note 72, at 306–07.
162. Nahman, *supra* note 19, at 629 (demonstrating that "the physicians' actions were in violation of Romanian law that prohibits payment for human ova and organs, therefore the destination country (Romania) pressed charges").
163. For a review of scholarly work, *see*Hudson, Nicky; , et al. Cross-Border Reproductive Care: A Review of the Literature. 22Reprod. BioMed. Online. :673, 683.2011; [PubMed: 21498121] (pointing-out that the literature regarding the regulation of cross-border reproductive markets has mainly focused on issues concerning the infertile couples or, on the resulting children (the difficulties of traveling to another country, and the need to beware of foreseeable medical harm to the future child, or to the intended mother)); *see* Storrow, *supra* note 72, at 324–25. Regarding surrogacy, *see*Inhorn, Marcia C; Patrizio, Pasquale. Rethinking Reproductive "Tourism" as Reproductive "Exile". 92Fertility & Sterility. :904.2009; [PubMed: 19249025] Regarding egg sale, *see*Pfeffer, Naomi. Eggs-Ploiting Women: A Critical Feminist Analysis of the Different Principles in Transplant and Fertility Tourism. 23Reprod. Biomedicine Online. :634, 638.2011; (pointing out that even the ESHRE Code of Practice is patient-centered, focused on how to ensure that clinics in destination countries offer safe and effective care to their clients, but does not mention the welfare of egg vendors).
164. The medical risks entailed have secondary impact for states that goes beyond the individual transaction. Medical complications can burden the healthcare systems in both consumers' and destination countries. The children born from the procedure might receive unsatisfactory care, or import diseases into the consumers' country. Consumers' countries might have to internalize the medical harms caused by an insufficient standard of medical care in destination countries. Regarding the self-interest of developed countries in the regulation of the medical services market, *see*Cohen, Glenn. Medical Tourism, Access to Health Care, and Global Justice. 1Can. J. Comp & Contemp. L. :161, 186.2009; Merlet, Françoise. Regulatory Framework in Assisted Reproductive Technologies, Relevance and Main Issues. 47Folia Histochemica et Cytobiologica. :S9, S12.2009; [PubMed: 20067901] (relating to different levels of safety that jeopardizes both consumers' countries and assisting women).
165. For possible models that could promise safety and basic rights as well as ensure fair terms, *see* Bassan, *Shared Responsibility supra* note139; Bassan, *Fair Trade supra* note 109.
166. *E.g.*, for human rights as the minimal threshold, *see*Pogge, Thomas. World Poverty and Human Rights (2). :25.2008It remains unclear whether the human rights common ground could meaningfully extend the principles of reproductive justice above a minimal human rights threshold.
167. Wertheimer, *supra* note 66, at 55 (arguing that harsh terms may be compensated by relatively generous price).
168. A measurement of "a fair" price is difficult. For possible calculations, *see* The Ethics Committee, *supra* note 96, at S243 (2004); Holland, *supra* note 8, at 269; *see*Rothenberg, Karen H. Feminism, Law, and Bioethics. 6Kennedy Inst. Ethics J. :69, 75.1996; [PubMed: 10157551] Tong, Rosemarie. Towards a Feminist Perceptive on Gamete Donation and Reception Policies. New Ways of Making Babies : The Case of Egg Donation. :138, 142.Cohen, Cynthia B1996Widdows, *supra* note 41, at 18 (considering payment according to the earning of consumers).
169. *See*Robertson, John A. Technology and Motherhood: Legal and Ethical Issues in Human Egg Donation. 39Case W. Res. :1, 31.1989;
170. Fraser, Nancy. From Redistribution to Recognition? Dilemmas of Justice in a 'Post-Socialist' Age. New Left Rev. :68, 82.1995
171. For recognition and respect for rights as legitimizing an aim, see Tobin, *supra* note 19, at 325.
172. Kalfoglou & Geller, *supra* note 123, at 665.
173. *Id.* at 665.

174. *Id.* at 662.
175. Kalfoglou 2000, *supra* note 67, at 663.
176. *Id.* at 663–664.
177. Pande, Amrita. “It May Be Her Eggs But It’s My Blood”: Surrogates and Everyday Forms of Kinship in India. 32Qualitative Soc. :379, 392.2009; (emphasis added) [hereinafter Pande, *My Blood*].
178. SAMA, *supra* note 75, at 76.
179. *Id.* at 103–04 (emphasis added).
180. Daniels, Ken R. To Give or Sell Human Gametes – The Interplay Between Pragmatics, Policy and Ethics. 26J. Med. Ethics. :206, 210.2000; [PubMed: 10860215]
181. For surrogacy, *see I am a Product of Surrogacy*, http://theothersideofsurrogacy.blogspot.co.il/; Pande, *My Blood supra* note 177, at 383 (interpreting the claims of surrogates according to which this blood/substance tie imparted identity to the child). For eggs, *see*Cook, Michael. The pain of anonymous parentage - A new US forum gives voice to the grown children of anonymous donors. Mercatornet. Jan 27.2011 http://www.mercatornet.com/articles/view/the_pain_of_anonymous_parentage/
182. Social Research, *supra* note 3636, at 56 (reporting that all surrogates wanted to have information about the child’s growth and whereabouts);.
183. Robertson, *supra* note 169, at 17.
184. *See* Kalfoglou & Geller, *supra* note 123, at 664.
185. For the hopes of surrogates, see, for example, Pande, *My Blood supra* note 177, at 388 (reporting that the surrogate Parvati hopes for a future connection with the intended parents and relates to them in a family-like way); Lipkin, Nuphar; Samama, Etti. Surrogacy in Israel - Status Report 2010 and Proposals for Legislative Amendment. :15.2010*available at:*http://isha.org.il/wp-content/uploads/2014/08/surrogacy_Eng001.pdf(reporting that from the surrogate mother’s point of view, the human relationship and gratefulness that she experiences with the intended parents is a major source of her sense that the procedure is an act of heroism and not of exploitation); *see* Rabinowitz, *supra* note 48.
186. Anderson, *supra* note 30, at 84; Pande, *My Blood, supra* note 177, at 380 (highlighting how the surrogates’ constructions of everyday kinship disrupt theories of relatedness that are based solely on biology and procreation, and showing that by emphasizing connections based on shared bodily substance and by deemphasizing genetic ties, the surrogates challenge established hierarchies in kin relationships—where genes and the male seed triumph above all).
187. *For surrogacy, see* Anderson, *supra* note 30, at 83 (“the surrogate industry has an interest in suppressing, manipulating, and trivializing her perspective, for there is an ever-present danger that she will see her involvement in her pregnancy from the perspective of a parent rather than from the perspective of a contract laborer.”); Scott, *supra* note 33, at 139–42 (showing that the move to gestational surrogacy has facilitated the change in the social meaning of surrogacy from a mother’s sale of her baby to a transaction involving “carriers,” rather than “mothers, providing gestational services). For the development of anonymous gamete donation in order to avoid the wish of providers to know the recipient, *see, e.g.*, Ertman, *supra* note 8, at 19 (regarding the social safeguard of anonymity of the sperm donor (protected by contract law) to protect the integrity of the new family that the recipient intends to create, which may imply that continuous relationship may harm such integrity).
188. *See*Dennison, Michelle. Revealing Your Sources: The Case For Non-Anonymous Gamete Donation. 21J. L. & Health. :1, 20.2007;
189. For egg donation, Daniels, *supra* note 181, at 210. For surrogacy, *see*Teman, Elly. Birthing a Mother: The Surrogate Body and the Pregnant Self. :26.2010(“the exchange of money for a set of services leaves the buyer and the seller with no mutual obligation because the exchange expresses a relationship of otherness, a lack of relationship“); Pande 2009, *supra* note 28, at 164 (“[T]he rules of commercial surrogacy meant that the termination of that relationship was rather abrupt. Dr Khanderia ensured that the baby was taken away right after delivery so that the surrogate had no opportunity to change her mind.”). Saravanan, *supra* note 10, at 9 (reporting that most parents did not want to keep any contact with the surrogates after the process; some surrogates did not receive any call, and one surrogate was even given wrong contact details by the consumers);

Trimmings & Beaumont, *supra* note 53, at 498 (reporting that in 11 out of 13 cases there was no family relationship between the intended parents and the surrogate mother).

190. For the right to know one's parentage as part of self-identity, *see, e.g.* Tobin, *supra* note 19, at 329–30.

191. *See*Shearing C. A Constitutive Conception of Regulation. Business Regulation and Australia's Future. :67, 69.Grabosky P, Braithwaite J. 1994

192. Tong, *supra* note 168, at 147–148. *E.g.* Elena's interview in Nahman, 2008, *supra* note104, at 72 (denying any kinship relationship with her egg, or the resulting child, saying he is not her own (although referring to it as 'my baby'). She therefore did not want any information about him.).